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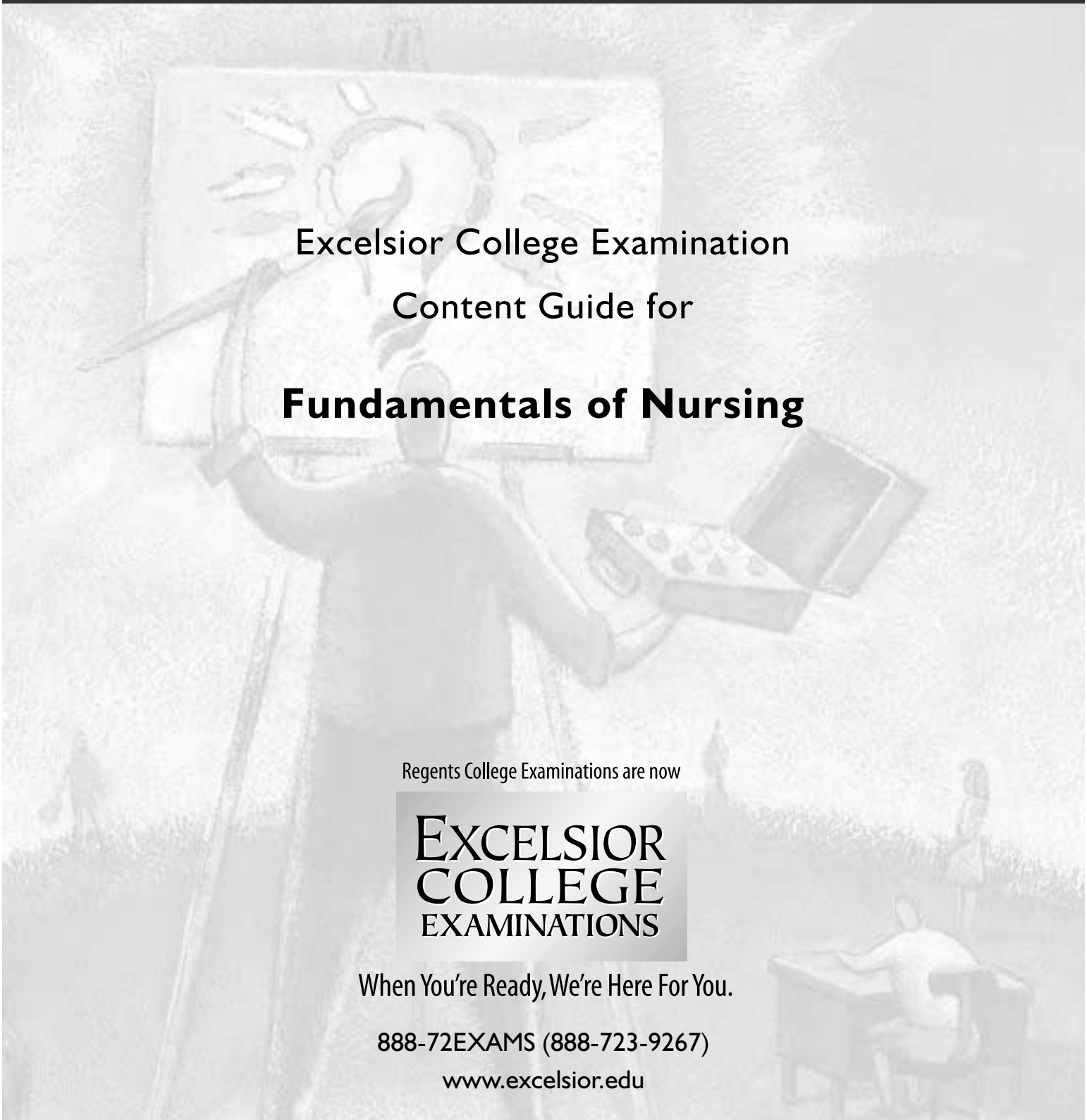

Excelsior College Examination Content Guide for

Fundamentals of Nursing

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Important information to help you prepare for this Excelsior College Examination

General Description of the Examination

The Excelsior College Examination in Fundamentals of Nursing examination measures knowledge and understanding of the material usually taught in a course in fundamentals of nursing in an associate degree nursing program. The examination assumes a basic knowledge of anatomy and physiology, chemistry, and mathematics. Questions on the examination focus on the health problems of adult patients that are commonly encountered by associate degree nurses in health care settings.

The examination requires you to demonstrate knowledge and understanding of the theoretical framework for each content area as well as the ability to apply this knowledge through use of the nursing process.

■ Uses for the Examination

Excelsior College, the test developer, recommends granting eight (8) semester hours of lower-level undergraduate credit to students who receive a letter grade of C or higher on this examination. This recommendation is endorsed by the American Council on Education. Other colleges and universities also recognize this exam as a basis for granting credit or advanced standing. Individual institutions set their own policies for the amount of credit awarded and the minimum acceptable score. Before taking the exam, you should check with the institution from which you wish to receive credit to determine whether credit will be granted and/or to find out the minimum grade required for credit.

■ Examination Length and Scoring

The examination consists of approximately 160 four-option multiple-choice questions, some of which are unscored, pretest questions. You will have three (3) hours to complete the examination. Since you will not be able to tell which questions are being pretested, you should do your best on all of them. Scores are based on ability level as defined in the item response theory (IRT) method of exam development, rather than simply on your total number of correct answers. Your score will be reported as a letter grade.

■ Examination Administration

The examination is administered by computer at Prometric Testing Centers®* throughout the United States and in Canada, American Samoa, Guam, Puerto Rico, Saipan (Northern Mariana Islands), and the Virgin Islands. The examination is also administered at approved international testing centers. To receive information concerning testing dates, locations, and fees, contact Excelsior College.

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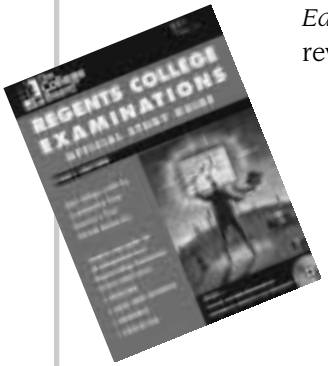

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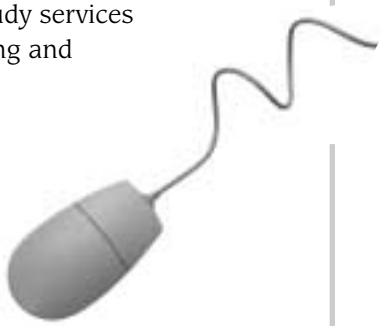

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Content Outline

The major content areas on the examination and the percent of the examination devoted to each content area are listed below.

CONTENT AREA	PERCENT OF THE EXAMINATION
I. The Profession of Nursing	8%
II. Communication and Interpersonal Relations	10%
III. Protection and Promotion of Safety	25%
IV. Comfort, Rest, and Activity	15%
V. Nutrition	10%
VI. Elimination	11%
VII. Oxygenation	10%
VIII. Fluid and Electrolyte Balance	11%
Total	100%

■ Note Concerning Wording of Nursing Diagnosis

The North American Nursing Diagnosis Association (NANDA) continually revises and updates its listing of diagnostic categories, defining characteristics, and etiological factors. For example, between 1989 and 1991 the term "potential" was revised to "high risk." However, questions on the examination that include nursing diagnoses are not intended to test your knowledge of current wording or phrasing. The questions are intended to test your ability to recognize nursing diagnoses that result from nursing assessments. For the purposes of the examination, all diagnoses should be considered correctly worded, even if a newer version of the diagnostic wording is being used by NANDA.

I. The Profession of Nursing (8%)

A. Legal issues in nursing

1. General legal concepts: statutory, common, civil, and criminal laws
2. Nurse practice acts
   a. Definition and purposes of nurse practice acts
   b. Impact on the practice of nursing
   c. ANA Standards of Care
   d. Licensure: legal requirements, grounds for revocation, grounds for suspension
3. Legal liability in nursing
   a. Types of crimes: felonies, misdemeanors
   b. Areas of liability: torts, negligence, invasion of privacy, defamation of character, assault and battery, false imprisonment, abandonment
   c. Good Samaritan Laws
   d. Informed consent
   e. A Patient's Bill of Rights

B. Roles and functions of the nurse

1. Caregiver
2. Decision maker
3. Communicator
4. Manager of care
5. Advocate
6. Teacher

C. Ethics and values in nursing

1. ANA Code of Ethics
2. Resolution of ethical problems
3. Nature and function of values

D. Basic nursing concepts

1. The health continuum
   a. Wellness-illness continuum
   b. Factors influencing health
      1) Individual factors (for example: genetics, age)
      2) Environmental factors (for example: occupational hazards, stress)
      3) Socioeconomic and cultural factors (for example: lifestyle, single-parent households, fast foods, health practices)
   c. Effects of hospitalizations and/or illness (for example: loss of income, change in self-image, disruption of family)
2. The health care delivery system
3. Maslow's hierarchy of needs
   a. Structure of hierarchy
   b. Implication for nursing care
4. Homeostasis and adaptation to stress
   a. General concepts of homeostasis and regulatory mechanisms
   b. General concept and nature of stress based on Selye's theory
   c. Factors influencing adaptation (for example: age, lifestyle, occupation, coping strategies)
   d. Psychophysiological signs of increased stress (for example: changes in vital signs, memory or perceptual changes)
5. Psychophysiological adaptations to stress (for example: fight or flight response, rest and activity changes, defense mechanisms)

E. Nursing process methodology

1. Purposes
2. Steps
   a. Assessment: establishing a database concerning patient needs, including gathering subjective and objective data and assessing individual factors related to health
   b. Diagnosis: identification of the patient's actual or potential nursing diagnoses after analyzing and interpreting data
   c. Planning: setting priorities, identifying patient-centered outcomes and selecting nursing interventions to achieve those outcomes using clinical pathways
   d. Implementation: using nursing interventions to help the patient achieve goals
   e. Evaluation: determining the extent to which outcomes have been achieved
3. Elements of a nursing diagnosis statement according to North American Nursing Diagnosis Association Taxonomy, 1997
4. Characteristics of a goal: measurable, patient-oriented, attainable with a specified time period

F. Recording and reporting

1. Concepts and principles
   a. Purposes of recording: charting, documentation (for example: providing a record of care given, charting patient's response to care, evaluation and revision of the nursing care plan)
   b. Purposes of reporting: intermittent, change-of-shift (for example: promoting continuity of patient care, evaluation of effectiveness of nursing interventions)

c. Principles of written communication (for example: accuracy, legibility, legality, abbreviations)

d. Principles of oral communication (for example: objectivity, clarity, timeliness)

2. Inclusion of appropriate information when recording and reporting (for example: when using narrative method, when using SOAP method; on a medication administration record, on a nursing care plan, in a team conference, at change-of-shift)

II. Communication and Interpersonal Relations (10%)

A. Theoretical framework

1. Therapeutic communication
   a. Definition and goals
   b. Types of communication: verbal, nonverbal
   c. Principles of therapeutic communication
      1) Techniques that facilitate communication
      2) Techniques that block communication

2. The nurse-patient relationship
   a. Definition and outcomes of the nurse-patient relationship
   b. Components of the nurse-patient relationship
   c. Phases of the nurse-patient relationship

3. Factors influencing the communication process (for example: cultural, sensory losses, language barriers, perception of the relationship, personal experiences and needs, attitudes)

4. Patient instruction: principles of teaching/learning

B. Nursing care

1. Assessment: establish a database concerning communication
   a. Gather objective and subjective data (for example: primary language, use of sign language, unable to read, hearing ability)
   b. Assess factors influencing communication and the nurse-patient relationship (see IIA3)

2. Diagnosis: identify the patient's actual or potential nursing diagnoses related to communication
   a. Analyze and interpret data (for example: patterns of communication, readiness for learning)
   b. Identify nursing diagnoses (for example: impaired verbal communication related to oral surgery; knowledge deficit: low-calorie diet related to recently ordered therapy)

3. Planning: set priorities, identify patient-centered outcomes and select interventions related to communication
   a. Set priorities and establish outcomes (for example: patient will communicate needs using an alternate means of communication [chalkboard]; patient will make appropriate meal selections)
   b. Incorporate factors influencing communication in planning patient care (see IIA3)
   c. Select nursing interventions to facilitate communication (for example: provide the patient with a "magic slate"; select materials appropriate to the patient's educational level)

4. Implementation: use nursing interventions to achieve outcomes related to communication and the nurse-patient relationship
    a. Use facilitative communication techniques (see IIA1c)
    b. Establish a therapeutic nurse-patient relationship (see IIA2)
5. Evaluation: determine the extent to which outcomes have been achieved
    a. Evaluate, record, and report the patient's response to nursing actions (for example: due to sedation, patient is not able to use the magic slate; patient selects foods appropriate to a low-calorie diet)
    b. Modify the plan of care if necessary

III. Protection and Promotion of Safety (25%)

A. Asepsis

1. Theoretical framework
    a. Chain of infection
    b. Principles of medical and surgical asepsis
    c. Methods of transmission (for example: direct contact, vehicles, airborne)
    d. Standard (universal) precautions
    e. Factors influencing an individual's susceptibility to infection (for example: stress, nutritional status, physical status, medications, heredity, lifestyle, socioeconomic status, occupation)
2. Nursing care
    a. Assessment: establish a database concerning asepsis
        1) Gather objective and subjective data (for example: WBC count [normal values], history of exposure to pathogens, fever, thirst)
        2) Assess factors influencing susceptibility to infection (see IIIA1e)
    b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to asepsis
        1) Analyze and interpret data (for example: identify pathogen and possible method of transmission)
        2) Identify nursing diagnoses (for example: high risk for infection related to poor nutritional status and exposure to pathogens)
    c. Planning: set priorities, identify patient-centered outcomes and select appropriate interventions related to asepsis
        1) Set priorities and establish outcomes (for example: patient will wash hands after using the toilet)
        2) Incorporate factors influencing the individual's susceptibility to infection (see IIIA1e)
        3) Select nursing interventions to help the patient achieve the outcomes (for example: utilize appropriate aseptic measures, determine appropriate barriers)
    d. Implementation: use nursing interventions to achieve the outcomes related to asepsis
        1) Use nursing measures to contain organisms (for example: use medical asepsis)
        2) Use nursing measures to exclude organisms (for example: use surgical asepsis when providing wound care)
        3) Instruct the patient regarding prevention of infection (for example: handwashing)
    e. Evaluation: determine the extent to which outcomes have been achieved
        1) Evaluate, record, and report the patient's response to nursing actions (for example: wound is approximated and free of drainage)

2) Continually reassess the physical environment (for example: dressings are disposed of in a closed container)

3) Modify the plan of care if necessary

B. The body's defenses (includes the body systems, the immune system, and the inflammatory response)

1. Theoretical framework
   a. Physiological responses (for example: antigen-antibody response, leukocytosis, signs of inflammation, secretion of mucus, movement of cilia, removal of waste products, wound healing, fever)
   b. Factors influencing the body's defenses
      1) Individual factors (for example: age, nutritional status, skin integrity, hygienic practices, physical activity, health status, cigarette smoking)
      2) Environmental factors (for example: climate, occupational hazards, exposure to communicable diseases, cigarette smoke, radiation)
   c. Techniques commonly used to promote the body's defenses (for example: application of heat and cold, tetanus booster, flu vaccine)
2. Nursing care
   a. Assessment: establish a database concerning defenses
      1) Gather objective and subjective data (for example: condition of the patient's skin and mucous membrane, vital signs, redness, pain, swelling, WBC count, history of immunizations)
      2) Assess factors influencing the body's defenses (see IIIB1b)
   b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to defenses
      1) Analyze and interpret data (for example: culture reports, identify impairment of the skin, WBC count [normal values], characteristics of drainage)
      2) Identify nursing diagnoses (for example: high risk for infection related to altered skin integrity)
   c. Planning: set priorities, identify patient-centered outcomes and select interventions related to defenses
      1) Set priorities and establish outcomes (for example: patient will remain afebrile)
      2) Incorporate factors influencing the body's defenses (see IIIB1b)
      3) Select nursing interventions to help the patient achieve the outcomes (for example: monitor vital signs q4h)
   d. Implementation: use nursing interventions to achieve outcomes related to the body's defenses
      1) Use nursing measures to promote the body's defenses (for example: provide adequate nutrition, apply heat and cold treatments, provide wound care, collect specimens for culture)
      2) Instruct the patient to support and/or restore the body's defenses (for example: emphasize the need to avoid exposure to infectious agents)
   e. Evaluation: determine the extent to which outcomes have been achieved
      1) Evaluate, record, and report the patient's response to nursing actions (for example: patient's temperature remains within normal limits)
      2) Modify the plan of care if necessary

C. Medication administration

1. Theoretical framework
    a. Pharmacokinetics: absorption, distribution, metabolism, excretion
    b. Principles of administration: calculations (including equivalents), routes and sites, safety measures, controlled substances, use of nasogastric and gastrostomy tubes, transcribing medication orders
    c. Factors influencing medication action and effectiveness (for example: age, sex, weight, psychological factors, time of administration, environment)
2. Nursing care
    a. Assessment: establish a database concerning the patient's medication regimen
        1) Gather objective and subjective data (for example: history of allergies, vital signs, duration of pain)
        2) Assess factors influencing medication action and effectiveness (see IIIC1c)
    b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to medications
        1) Analyze and interpret data (for example: changes in vital signs, recognize side effects)
        2) Identify nursing diagnoses (for example: noncompliance related to fear of side effects)
    c. Planning: set priorities, identify patient-centered outcomes and select interventions related to the patient's medication regimen
        1) Set priorities and establish outcomes (for example: patient will adhere to regimen as agreed)
        2) Incorporate factors influencing medication action and effectiveness (see IIIC1c)
        3) Select nursing interventions to help the patient achieve outcomes (for example: instruct the patient to take the medication with food)
    d. Implementation: use nursing interventions to achieve outcomes related to the medication regimen
        1) Use nursing measures to safely administer medications (for example: calculation and measurement, patient identification, transcription, accurate recording, selection of correct site, administration of controlled substances)
        2) Provide information and instruction regarding the medication regimen (for example: self-administration, storage, reporting side effects)
    e. Evaluation: determine the extent to which outcomes have been achieved
        1) Evaluate, record, and report the patient's response to nursing actions (for example: patient adheres to the medication regimen)
        2) Modify the plan of care if necessary

D. Safety

1. Theoretical framework
    a. Factors influencing an individual's safety
        1) Individual factors (for example: age, medications, level of awareness, sensory perception, emotional state)
        2) Environmental factors (for example: occupation, presence of lead paint)
        3) Socioeconomic and cultural factors (for example: ability to communicate, unemployment)
        4) Psychological factors (for example: stress, anxiety)

b. Identification of environmental hazards (for example: physical and mechanical, thermal, chemical, radiation, ecological)

c. Devices commonly used to promote safety (for example: restraints, walkers, siderails)

2. Nursing care

a. Assessment: establish a database concerning the patient's safety needs

1) Gather objective and subjective data (for example: confusion, visual acuity)

2) Determine presence of environmental hazards (see IIID1b)

3) Assess factors influencing the patient's safety (for example: age, hearing impairment) (see IIID1a)

b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to safety

1) Analyze and interpret data (for example: recognize loss of equilibrium)

2) Identify nursing diagnoses (for example: high risk for injury related to sensory deficit)

c. Planning: set priorities, identify patient-centered outcomes and select interventions related to safety

1) Set priorities and establish outcomes (for example: patient will request assistance with ambulation)

2) Incorporate factors influencing safety in planning for individualized patient care (for example: consider age, lifestyle, level of consciousness, mobility)

3) Select nursing interventions for alleviating or minimizing safety hazards (for example: modify the environment)

4) Select the appropriate safety device based on the individual's needs (for example: walkers, restraints)

d. Implementation: use nursing interventions to achieve outcomes related to safety

1) Use nursing measures to provide a safe environment (for example: elevate siderails, use restraining jacket)

2) Use equipment and devices safely (for example: walkers, ice packs, heat applications)

3) Instruct the patient regarding safety (for example: orient to environment, explain use of wheelchair)

e. Evaluation: determine the extent to which outcomes have been achieved

1) Evaluate, record, and report the patient's response to nursing actions (for example: patient ambulates with the nurse's assistance)

2) Modify the plan of care if necessary

IV. Comfort, Rest, and Activity (15%)

A. Hygiene

1. Theoretical framework

a. Components of hygiene

b. Factors influencing hygiene (for example: cultural factors, age, physical status, body image, self-esteem)

c. Agents commonly used on the skin and mucous membrane (for example: soaps, lotions, emollients, mouthwashes)

2. Nursing care
    a. Assessment: establish a database concerning hygiene
        1) Gather objective and subjective data (for example: cleanliness of the skin, condition of the nails, complaints of dryness)
        2) Assess factors influencing the patient's hygiene (see IVA1b)
    b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to hygiene
        1) Analyze and interpret data
        2) Identify nursing diagnoses (for example: altered oral mucous membrane related to mouth breathing)
    c. Planning: set priorities, identify patient-centered outcomes and select interventions related to hygiene
        1) Set priorities and establish outcomes (for example: patient's oral mucous membrane will be pink and moist)
        2) Incorporate factors influencing hygiene in planning patient care (see IVA1b)
        3) Select nursing interventions to achieve outcomes (for example: provide mouth care q2h)
    d. Implementation: use nursing interventions to achieve outcomes related to hygiene
        1) Use nursing measures to provide comprehensive hygienic care (for example: bathing, hair care, nail care, skin care, perineal care)
        2) Use nursing measures to promote psychological comfort (for example: provide privacy during bathing)
        3) Provide information and instruction (for example: instruct the patient on the use of dental floss, discuss indications for use of skin lotions rather than alcohol-base skin products)
    e. Evaluation: determine the extent to which outcomes have been achieved
        1) Evaluate, record, and report the patient's response to nursing actions (for example: the patient's lips remain dry and cracked)
        2) Modify the plan of care if necessary

B. Rest and sleep

1. Theoretical framework
    a. Principles related to rest and sleep (for example: sleep stages, circadian rhythm)
    b. Factors influencing rest and sleep (for example: age, noise level, fatigue, use of caffeine, use of alcohol, hospitalization, sensory deprivation)
    c. Agents commonly used to promote rest and sleep (sedatives, hypnotic)
2. Nursing care
    a. Assessment: establish a database concerning rest and sleep
        1) Gather objective and subjective data (for example: usual sleep habits, use of over-the-counter medications, bedtime routines)
        2) Assess factors influencing the patient's rest and sleep (see IVB1b)
    b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to rest and sleep
        1) Analyze and interpret data (see IVB2a)
        2) Identify nursing diagnoses (for example: sleep pattern disturbance related to unfamiliar surroundings)

c. Planning: set priorities, identify patient-centered outcomes and select interventions

1) Set priorities and establish outcomes (for example: patient will get six hours of uninterrupted sleep per night)

2) Incorporate factors influencing rest and sleep (see IVB1b)

3) Select nursing interventions to help the patient achieve outcomes (for example: reorient the patient to the surroundings)

d. Implementation: use nursing interventions to achieve outcomes related to rest and sleep

1) Use nursing measures to induce rest and sleep (for example: administer a backrub, provide a bedtime snack, provide a quiet environment)

2) Use nursing measures specific to drug classifications for prescribed medications (for example: raise the siderails after administering a sleep medication)

3) Use nursing measures to modify the environment (for example: provide sensory stimulation, prevent sensory overload)

4) Provide information and instruction (for example: discuss relaxation techniques with the patient)

e. Evaluation: determine the extent to which outcomes have been achieved

1) Evaluate, record, and report the patient's response to nursing actions (for example: patient states that he feels well rested)

2) Modify the plan of care if necessary

C. Mobility and immobility

1. Theoretical framework

a. Principles of body mechanics, transfer, ambulation, range-of-motion, exercise

b. Responses of body systems to mobility (for example: improved circulation, peristalsis)

c. Complications resulting from immobility (for example: muscle weakness, contractures, retained secretions, decubitus ulcers, hypostatic pneumonia, constipation)

2. Nursing care

a. Assessment: establish a database concerning mobility and immobility

1) Gather objective and subjective data (for example: range-of-motion, skin integrity, elimination patterns, activity level, joint mobility)

2) Assess the patient's responses to mobility and immobility (see IVC1b–c)

b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to mobility or immobility

1) Analyze and interpret data

2) Identify nursing diagnoses (for example: high risk for impaired physical mobility related to bed rest)

c. Planning: set priorities, identify patient-centered outcomes, and select appropriate interventions related to mobility or immobility

1) Set priorities and establish outcomes (for example: patient will maintain usual range of motion in all joints)

2) Consider the responses of the body to mobility and immobility (see IVC1b–c)

3) Select nursing interventions to help the patient achieve outcomes (for example: supervise the patient in active range-of-motion exercises t.i.d.)

d. Implementation: use nursing interventions to achieve outcomes related to mobility or immobility

1) Use appropriate devices to maintain normal body alignment (for example: footboard, pillows, trochanter roll)

2) Use nursing measures to promote mobility and maintain muscle tone (for example: range of motion, ambulation, positioning)

3) Use nursing measures to prevent tissue breakdown (for example: massage, pressure-relieving devices, turning)

4) Use nursing measures to prevent complications related to immobility (for example: leg exercises, antiembolism stockings, deep breathing and coughing)

5) Instruct the patient regarding activity needs

e. Evaluation: determine the extent to which outcomes have been achieved

1) Evaluate, record, and report the patient's response to nursing actions (for example: patient's joints are freely movable within normal range of motion)

2) Modify the plan of care if necessary

D. The pain experience

1. Theoretical framework

a. Concepts related to pain (for example: gate control theory, acute vs. chronic pain, pain threshold, endorphins)

b. Factors influencing pain (for example: etiology of pain, duration of pain, sensory overload, cultural factors)

c. Agents and techniques commonly used to control pain (for example: guided imagery, relaxation, administration of nonnarcotic analgesics, narcotic analgesics, patient-controlled analgesia, placebos, cutaneous stimulation)

2. Nursing care

a. Assessment: establish a database concerning pain

1) Gather objective and subjective data (for example: changes in vital signs, facial expression, body language, verbalization by the patient)

2) Assess factors influencing the patient's pain (see IVD1b)

b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to pain

1) Analyze and interpret data

2) Identify nursing diagnoses (for example: pain related to recent abdominal surgery)

c. Planning: set priorities, identify patient-centered outcomes and select interventions related to pain

1) Set priorities and establish outcomes (for example: patient will report decrease in pain)

2) Incorporate factors influencing pain (see IVD1b)

3) Select nursing interventions to help the patient achieve outcomes (for example: position the patient to minimize stress on the incision; administer pain medication on a regular schedule)

d. Implementation: use nursing interventions to achieve outcomes related to pain

1) Use nursing measures to reduce the patient's pain (for example: positioning, cutaneous stimulation, assess the operative site, promote relaxation)

2) Use nursing measures specific to drug classifications for prescribed medications (for example: monitor vital signs for a patient receiving a narcotic analgesic, schedule administration of medications to maximize effectiveness)

3) Instruct the patient regarding pain (for example: use of relaxation techniques, use of guided imagery)

e. Evaluation: determine the extent to which outcomes have been achieved

1) Evaluate, record, and report the patient's response to nursing interventions (for example: patient states that pain has been relieved)

2) Modify the plan of care if necessary

V. Nutrition (10%)

A. Theoretical framework

1. Processes of ingestion, digestion, and absorption of nutrients
2. Normal nutritional requirements
   a. Food Guide Pyramid
   b. Basic functions and common food sources of carbohydrates, proteins, fats, vitamins, minerals
   c. Caloric values
3. Common nutritional disturbances (for example: vomiting, heartburn, obesity, anorexia, malnutrition)
4. Factors influencing nutrition
   a. Individual factors (for example: age, sedentary lifestyle, vegetarian diet, dental status, physical condition, need for assistance with feeding)
   b. Socioeconomic and cultural factors (for example: income, religion)
   c. Psychological factors (for example: fad diets, anorexia)
5. Adaptations of normal diet: definitions, foods allowed, and indications for use
   a. Clear liquid
   b. Full liquid
   c. Soft
6. Alternative feeding methods (for example: gavage, gastrostomy)
7. Agents commonly used to promote nutrition (for example: vitamins and minerals)

B. Nursing care

1. Assessment: establish a database concerning nutritional status
   a. Gather objective and subjective data (for example: weight, height, anorexia)
   b. Assess factors influencing nutrition (see VA4)
2. Diagnosis: identify the patient's actual or potential nursing diagnoses related to nutrition
   a. Analyze and interpret data (for example: serum albumin, body weight)
   b. Identify nursing diagnoses (for example: altered nutrition: less than body requirements related to anorexia)
3. Planning: set priorities, identify patient-centered outcomes and select interventions related to nutrition
   a. Set priorities and establish outcomes (for example: patient will gain one pound per week until ideal body weight is achieved)
   b. Incorporate factors influencing nutrition in planning for patient's dietary needs (for example: plan nutritionally adequate diet based on patient's cultural preferences) (see VA4)
   c. Select nursing interventions to help the patient achieve outcomes related to nutrition
4. Implementation: use nursing interventions to achieve outcomes related to nutrition
   a. Use nursing measures to increase nutritional intake (for example: assist in food selection, assist in feeding, modify the environment, place the patient in the most appropriate position)

b. Use nursing measures appropriate to particular feeding methods (for example: nasogastric tube feedings, gastrostomy tube feedings)

c. Use nursing measures specific to drug classifications for prescribed medications (for example: administer liquid iron through a straw)

d. Instruct the patient regarding nutrition

5. Evaluation: determine the extent to which outcomes have been achieved

a. Evaluate, record, and report the patient's response to nursing interventions (for example: the patient has gained two pounds this week)

b. Modify the plan of care if necessary

VI. Elimination (11%)

A. Theoretical framework

1. Urinary elimination

a. Anatomy and physiology of urinary tract

b. Common disturbances (for example: incontinence, frequency, retention)

2. Intestinal elimination

a. Anatomy and physiology of intestinal tract

b. Common disturbances (for example: constipation, diarrhea, impaction, flatulence, incontinence)

3. Factors influencing elimination

a. Individual factors (for example: age, activity level, dietary habits)

b. Environmental factors (for example: privacy)

c. Psychological factors (for example: stress)

4. Agents commonly used to promote elimination (for example: laxatives, stool softeners, antidiarrheal agents)

B. Nursing care

1. Assessment: establish a database concerning elimination

a. Gather objective and subjective data (for example: changes in normal elimination patterns; color, odor, and consistency of urine and feces)

b. Assess factors influencing elimination (see VIA3)

2. Diagnosis: identify the patient's actual or potential nursing diagnoses related to elimination

a. Analyze and interpret data (for example: urinalysis, [normal values], frequency of elimination, intake and output, presence of occult blood)

b. Identify nursing diagnoses (for example: constipation related to insufficient intake of dietary fiber)

3. Planning: set priorities, identify patient-centered outcomes and select interventions related to elimination

a. Set priorities and establish outcomes (for example: patient will have one soft brown stool daily)

b. Incorporate factors influencing elimination in planning patient care (for example: the patient is on bed rest) (see VIA3)

c. Select nursing interventions to help the patient achieve outcomes (for example: consult with the dietician about increasing fiber in the patient's diet)

4. Implementation: use nursing interventions to achieve outcomes related to elimination

a. Use nursing measures to facilitate elimination (for example: perform catheterization, administer enema, administer laxatives and stool softeners, provide appropriate intake, collect specimens, ensure appropriate activity, decrease stress, provide proper positioning, ensure privacy)

b. Use nursing measures specific to drug classifications for prescribed medications (for example: administer a laxative at the time that evacuation is desired, encourage the patient to retain the suppository for 15 minutes)

c. Instruct the patient regarding elimination (for example: assist patient to plan an exercise program and to increase intake of fluids)

5. Evaluation: determine the extent to which outcomes have been achieved

a. Evaluate, record, and report the patient's response to nursing actions (for example: patient reports passing a hard, dry stool)

b. Modify the plan of care if necessary

VII. Oxygenation (10%)

A. Theoretical framework

1. Normal respiratory functions

a. Anatomy and physiology

b. Ventilation, diffusion, and transport

2. Common respiratory disturbances (for example: dyspnea, tachypnea, orthopnea, hypoxia)

3. Factors influencing oxygenation

a. Individual factors (for example: fever, activity level, excess secretions)

b. Environmental factors (for example: smoking, room ventilation)

c. Psychological factors (for example: stress, anxiety)

4. Techniques commonly used to promote oxygenation (for example: administration of oxygen via nasal cannula and face mask, incentive spirometry, chest physiotherapy)

B. Nursing care

1. Assessment: establish a database concerning oxygenation status

a. Gather objective and subjective data (for example: skin color, tolerance for activity, vital signs, respiratory status, shortness of breath, confusion, restlessness)

b. Assess factors influencing oxygenation (see VIIA3)

2. Diagnosis: identify the patient's actual or potential nursing diagnoses related to oxygenation

a. Analyze and interpret data (for example: vital signs, hemoglobin, hematocrit [normal values])

b. Identify nursing diagnoses (for example: ineffective breathing pattern related to abdominal pain)

3. Planning: set priorities, identify patient-centered outcomes and select interventions related to oxygenation

a. Set priorities and establish outcomes (for example: patient will demonstrate increased depth of respiration)

b. Incorporate factors influencing oxygenation in planning patient care (for example: pain assessment, anxiety, positioning)

c. Select nursing interventions to help the patient achieve outcomes (for example: provide comfort measures, reposition the patient, administer the prescribed analgesic)

4. Implementation: use nursing interventions to achieve outcomes related to oxygenation

a. Use nursing measures to promote oxygenation (for example: turning, deep breathing, and coughing; administering oxygen; nasopharyngeal suctioning; monitoring vital signs; reducing anxiety)

b. Use nursing measures appropriate to the method of oxygen administration (humidifiers, oxygen masks, cannula)

c. Instruct the patient regarding oxygenation (for example: demonstrate coughing and deep-breathing exercises)

5. Evaluation: determine the extent to which outcomes have been achieved
   a. Evaluate, record, and report the patient's response to nursing actions (for example: patient's respirations are 12–14/minute, deep and rhythmic)
   b. Modify the plan of care if necessary

VIII. Fluid and Electrolyte Balance (11%)

A. Concepts and principles

1. Principles related to fluid and electrolyte balance (for example: composition, regulation, and movement of fluid and electrolytes)
2. Common disturbances of fluid and electrolyte balance
   a. Hypercalcemia, hypocalcemia
   b. Hyperkalemia, hypokalemia
   c. Hypernatremia, hyponatremia
   d. Hypermagnesemia, hypomagnesemia
   e. Hypervolemia, hypovolemia
3. Common intravenous fluids
   a. Lactated Ringer's
   b. 5% dextrose and water
   c. Normal saline
   d. Half saline
4. Factors influencing fluid and electrolyte balance
   a. Physical status (for example: vomiting, fever, diarrhea, use of diuretics, exercise)
   b. Environmental factors (for example: temperature, humidity)
5. Agents commonly used to promote fluid and electrolyte balance (for example: administration of IV fluids, electrolyte supplements)

B. Nursing care

1. Assessment: establish a database concerning fluid and electrolyte status
   a. Gather objective and subjective data (for example: skin turgor, pulse quality, condition of oral mucous membranes, output, weight, edema, muscle weakness, thirst)
   b. Assess factors influencing fluid and electrolyte status (see VIIIA4)
2. Diagnosis: identify the patient's actual or potential nursing diagnoses related to fluids and electrolytes
   a. Analyze and interpret data (for example: serum electrolyte level, hematocrit [normal values] specific gravity of urine [normal values])
   b. Identify nursing diagnoses (for example: fluid volume deficit related to insufficient intake)
   c. Planning: set priorities, identify patient-centered outcomes and select appropriate interventions related to fluids and electrolytes
   d. Set priorities and establish outcomes (for example: patient's total fluid intake will be 2,500 cc/day)
   e. Incorporate factors influencing fluid and electrolyte status (for example: establish a pattern of fluid intake based on individual patient preferences) (see VIIIA4)
   f. Select nursing interventions to help the patient achieve outcomes (for example: monitor IV therapy, provide oral fluids)

3. Implementation: use nursing interventions to achieve outcomes related to fluid and electrolyte balance
    a. Promote fluid and electrolyte balance (for example: assist with food and fluid selection, measure and record intake and output)
    b. Use nursing measures appropriate to oral and parenteral replacement (for example: establish daily fluid regimen with patient, assist with parenteral administration of fluids [gravity flow and IV infusion pumps], identify signs and symptoms of untoward reactions)
    c. Instruct the patient regarding fluid and electrolyte requirements (for example: discuss dietary sources of potassium)
4. Evaluation: determine the extent to which outcomes have been achieved
    a. Evaluate, record, and report the patient's response to nursing actions (for example: patient's 24-hour fluid intake is 2,500 cc)
    b. Modify the plan of care if necessary

Sample Questions

The questions that follow illustrate those typically found on this examination. These sample questions are included to familiarize you with the type of questions you will find on the examination. The answers can be found on the inside back cover of this guide.

1. A mentally competent patient refuses an injection. The nurse administers the injection despite the patient's refusal. In this situation, the nurse can be held liable for which offense?
   1) assault
   2) battery
   3) invasion of privacy
   4) a misdemeanor

2. Which term describes the rules or principles that govern professional conduct?
   1) beliefs
   2) ethics
   3) morals
   4) values

3. A patient is being admitted to the hospital. The nurse notes that the patient's pulse and blood pressure are higher than they were on previous routine office visits. How should the nurse interpret these findings initially?

   The findings are indicative of
   1) the resistance stage of stress.
   2) an autonomic nervous system response.
   3) an inflammatory response.
   4) the local adaptation syndrome.

4. Which observation is most indicative of a localized infection?
   1) diaphoresis
   2) fatigue
   3) fever
   4) swelling

5. Which information in a patient's health history indicates that the patient is at risk for infection?
   1) The patient had mumps three years ago.
   2) The patient had rubella one year ago.
   3) The patient had a tetanus booster 12 years ago.
   4) The patient was a year late receiving the polio vaccine.

6. A patient is being discharged with an indwelling urinary catheter. Which instruction should the nurse give to the patient to help prevent a urinary tract infection?
   1) Allow the collection bag to fill completely before emptying it.
   2) Separate the catheter from the tubing when emptying the collection bag.
   3) Clamp the tubing before exercising or ambulating.
   4) Position the tubing so the urine flows into the collection bag.

7. Which assessment finding indicates that a hospitalized patient is at risk for physical injury?
   1) diminished lung sounds
   2) hyperactive bowel sounds
   3) weak right hand grasp
   4) bilateral +1 ankle edema

8. When administering a medication via the Z-track method, the nurse should include which action?
   1) Massage the site following the injection.
   2) Give the injection into subcutaneous tissue.
   3) Change the needle prior to the injection.
   4) Administer the medication rapidly.

9. When administering a medication to a patient with decreased liver function, the nurse should be most concerned with which mechanism of the drug's action?
    1) absorption
    2) distribution
    3) excretion
    4) metabolism

10. Which instruction should the nurse give to a patient who uses a bath oil?
    1) Be certain to remove all oil residue from the skin.
    2) Take precautions to prevent falls in the bathtub.
    3) Alternate the use of bath oil with a skin lotion.
    4) Use a washcloth to apply the bath oil.

11. To which stage of sleep will a patient return after being awakened for a treatment?
    1) the stage from which she was awakened
    2) the first stage of sleep
    3) the rapid eye movement stage
    4) the second stage of sleep

12. A patient is on bed rest. To avoid a complication of immobility, the nurse should give priority to which assessment?
    1) activity tolerance
    2) bowel sounds
    3) lung sounds
    4) urinary output

13. Which analgesic is most commonly associated with an increased incidence of gastric bleeding in older adults?
    1) acetaminophen (Tylenol)
    2) codeine
    3) indomethacin (Indocin)
    4) meperidine hydrochloride (Demerol)

14. Which measure should the nurse include in the plan of care for a patient who is experiencing pain?
    1) Implement pain relief measures before the pain becomes severe.
    2) Use the same pain relief measure for each pain experience.
    3) Administer pain medications on a predetermined schedule.
    4) Encourage the patient to increase the intervals between pain medication requests.

15. Which food is highest in saturated fat?
    1) butter
    2) margarine
    3) olive oil
    4) peanut oil

16. Which observation indicates that a patient is responding positively to oxygen therapy?
    1) dyspnea
    2) eupnea
    3) hyperpnea
    4) orthopnea

17. Which assessment data should alert the nurse to the likelihood that a patient may be experiencing fluid volume deficit?
    1) increased hematocrit
    2) leukocytosis
    3) distended neck veins
    4) peripheral edema

18. When a patient's serum sodium level is 129 mEq/L, the nurse should anticipate an order for which IV fluid?
    1) 5% dextrose in water
    2) 5% dextrose in 0.45% NaCl
    3) 5% dextrose in 0.9% NaCl
    4) lactated Ringer's solution

19. The physician orders an IV infusion of 1,000 cc 0.9% NaCl to run over 10 hours. The IV administration set delivers 10 drops per cc. The nurse should regulate the flow rate at how many drops per minute?
    1) 6 to 7
    2) 16 to 17
    3) 25 to 26
    4) 31 to 32

20. Which instructional technique should maximize independence for a patient who needs to limit sodium in the diet?
    1) Calculate the actual volume of salt in the patient's usual diet.
    2) Provide the patient with a list of foods that must be avoided.
    3) Give the patient a set of written, preplanned, low-sodium menus.
    4) Explain to the patient how to read and interpret food labels.

Learning Resources for this Exam

The study materials listed below are recommended by Excelsior College as the most appropriate resources to help you study for the examination. We recommend that you obtain one of the two textbooks listed below to use in preparing for the examination. Each of these textbooks provides very good coverage of the topics on the content outline. For information on ordering from the Excelsior College Bookstore, see p. 2. You may also find resource materials in college libraries, schools of nursing, medical schools, and hospitals. Public libraries may have some of the textbooks or may be able to obtain them through an interlibrary loan program.

You should allow sufficient time to obtain resources and to study before taking the exam.

Recommended Resources

Kozier, B., Erb, G., Blais, K., & Wilkinson, J. (1998). *Fundamentals of nursing: Concepts, process, and practice* (Updated 5th ed.). Menlo Park, CA: Addison-Wesley.

Study Guide:

Van Leuven, K. (1998). Study guide for *Fundamentals of nursing: Concepts, process, and practice* (Updated 5th ed.). Menlo Park, CA: Addison-Wesley.

OR

Taylor, C., Lillis, C., & Lemone, P. (1997). *Fundamentals of nursing: The art and science of nursing care* (3rd ed.). Philadelphia: J.B. Lippincott.

Study Guide:

Taylor, C., Lillis, C., & Lemone, P. (1997). *Study guide to accompany Fundamentals of nursing: The art and science of nursing care* (3rd ed.). Philadelphia: J.B. Lippincott.

Additional Resources

The examination development committee has also suggested the following textbooks which may provide further clarification of the content.

Cataldo, C., DeBruyne, L., & Whitney, E. (1996). *Nutrition and diet therapy: Principles and practices* (4th ed.). St. Paul, MN: West.

Kozier, B. et al. (1993). *Techniques in clinical nursing: A nursing process approach* (4th ed.). Menlo Park, CA: Addison-Wesley.

McKenry, L., & Salerno, E. (1995). *Mosby's Pharmacology in nursing* (19th ed.). St. Louis: Mosby.

Wilkinson, J. (1995). *Nursing diagnosis and intervention pocket guide* (6th ed.). Redwood City, CA: Addison-Wesley.

Notes

Notes

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Key To Sample Questions

Question	Key	Content Area[1]	Question	Key	Content Area[1]
1	2	IA3b	11	2	IVB1a
2	2	IC	12	3	IVC1c
3	2	IIB	13	3	IVD1c
4	4	IIIB2a	14	1	IVD2c
5	3	IIIB1b	15	1	VA2b
6	4	IIIB2c	16	2	VIIB1b
7	3	IIIB2a	17	1	VIIIA1
8	3	IIIC1b	18	3	VIIIB1b
9	4	IIIC2a	19	2	VIIIB3b
10	2	IIID2d	20	4	VIIIB3c

[1]Content Area refers to the location of the question topic in the content outline.

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Arts and Sciences	
Abnormal Psychology†	3*
American Dream†	6*
Anatomy & Physiology†	6
English Composition†	6
Ethics: Theory & Practice†	3*
Foundations of Gerontology	3*
History of Nazi Germany†	3*
Life Span Developmental Psychology†	3
Microbiology†	3
Organizational Behavior	3*
Pathophysiology	3*
Psychology of Adulthood & Aging	3*
Religions of the World†	3*
Research Methods in Psychology†	3*
Statistics†	3
World Population†	3*
Business	
Business Policy & Strategy	3△
Ethics: Theory & Practice	3*
Human Resource Management	3*
Labor Relations	3*
Organizational Behavior	3*
Production/Operations Management	3△
Education	
Reading Instruction in the Elementary School	6*

Examination	Credit Hrs.
Nursing: Associate Level	
Differences in Nursing Care: Area A (modified)①	4
Differences in Nursing Care: Area B①	5
Differences in Nursing Care: Area C②	5
Fundamentals of Nursing**	8
Maternal & Child Nursing (associate)**	6
Maternity Nursing**	3
Nursing Concepts 1	4
Nursing Concepts 2	4
Nursing Concepts 3	4
Occupational Strategies in Nursing②	3
Nursing: Baccalaureate Level	
Adult Nursing**	8*
Health Restoration: Area I	4*
Health Restoration: Area II	4*
Health Support A: Health Promotion & Health Protection	4*
Health Support B: Community Health Nursing	4*
Maternal & Child Nursing (baccalaureate)**	8*
Professional Strategies in Nursing	4*
Psychiatric/Mental Health Nursing**	8*
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* Indicates upper-level college credit. **These examinations do not apply toward the Excelsior College Nursing Degrees. †Guided Learning Packages are available for these exams. △Indicates lower-level college credit for Business Program, upper-level for Liberal Arts Program. ①Administered through Sept. 30, 2001. ②Administered through Sept. 30, 2002.

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